



## Privacy issues and Plan B: the Canadian Pharmacists Association responds

We find it surprising that *CMAJ*, an internationally respected medical journal, feels the need to create controversy at the expense of another health profession. In the December 6 issue, *CMAJ* dedicated 2 full pages to present its position that pharmacists' services are not professional or kept confidential, and that pharmacists should not be paid for the services they provide.<sup>1</sup> An editorial published in late March regards the consultation a pharmacist provides regarding emergency contraception (EC) as treating women as "fair game for unwanted questioning and unsought advice — at their own expense" and refers

to "a lingering paternalism in matters affecting women's reproductive health ... still hiding behind the counter."<sup>2</sup> These 2 articles certainly come across as part of a continued campaign by *CMAJ* against pharmacists.

Pharmacists are highly trained health professionals who practise under regulations, standards of practice and a code of ethics similar to that of physicians. For *CMAJ* to hold the position that a pharmacist can't ask a woman for her name negates the relationship that they have with their clients. If a woman does not wish to give her name, pharmacists can use their professional judgment and still provide the drug. However, her name and address would be required in provinces where reimbursement is made under a provincial health plan.

Imagine the outrage if the Canadian Pharmacists Association (CPhA) were to suggest that doctors should not ask a woman her name if she is asking for EC, or that they not be paid for the service they provide. Further, for *CMAJ* to suggest that the information a pharmacist collects is not kept confidential is irresponsible. Any information provided is private, secure and confidential, which would not be the case if the product was available in a convenience store or supermarket. Pharmacists will

dispense about 400 million prescriptions this year, many involving very personal information about treatment for HIV, sexually transmitted infections and mental illness, among other conditions.

*CMAJ*'s position flies in the face of the medical professions' recognition of the importance of collaborative, inter-professional practice where physicians and other health care providers have a clearly identified and valued role. The CPhA does, however, recognize that *CMAJ* does not necessarily represent the position of the CMA, with whom we have a valued collaborative relationship aimed at improving Canada's health care system. In fact, CMA's response to Health Canada's consultation on EC indicated support for the regulatory change and Schedule II status "on the condition that the change in the prescription status of levonorgestrel not deprive its users of the opportunity for counseling and follow-up, which are critical components of the promotion of sexual health." The College of Family Physicians of Canada, the Society of Obstetricians and Gynaecologists of Canada (SOGC) and the Canadian Nurses Association also supported this regulatory change and reviewed the CPhA guidelines and screening form.

The purpose of moving Plan B to Schedule II was to make it more accessible to women (thus reducing unwanted pregnancies and abortions), while still ensuring the appropriate level of counselling from a trained health professional. Pharmacists have no interest in a woman's sexual history except to determine if Plan B, which has maximum effectiveness for only 72 hours, is appropriate for their situation, as outlined in the assessment in SOGC's clinical practice guidelines on EC.<sup>3</sup> The guidelines are not new and represent best standards of practice. A physician or nurse practitioner would ask a woman requesting EC the same questions. Many women who ask for Plan B have a lot of questions and misinformation, and appreciate the opportunity to speak with a pharmacist. Pharmacists frequently find that a fair number of women who ask for EC do not, in fact, require it and therefore do not pay for or use an unnecessary drug. When providing EC, pharmacists also routinely refer women to a physician for long-term birth control and screening for STDs.<sup>4</sup>

It is interesting that the article concludes by admitting that no women have complained to privacy commissioners. We believe that women are actually benefiting from pharmacist counselling on EC, and this is an issue manufactured by *CMAJ* to grab some headlines. The real health issue that *CMAJ* should be addressing is that in Canada 1 in 4 pregnancies ends in abortion. Increased access to emergency contraception with an opportunity for the woman to consult with a health professional can significantly reduce the number of unwanted pregnancies.

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## [CMAJ responds:]

We agree that Plan B's nonprescription status is a step in the right direction.<sup>1</sup> We have no interest in waging a "campaign" against pharmacists, only in examining the potential impact of mandatory counselling on individual women. Our news article on emergency levonorgestrel (Plan B)<sup>2</sup> presents divergent points of view on behind-the-counter access, including that of the CPhA. Women we spoke to reported varying degrees of comfort with the dispensing process.

If controversy results from reporting on actual policies, so be it. The absence of direct complaints does not settle the matter; one may reasonably speculate that it indicates a general level of comfort with the dispensing procedure, but it may also reflect a lack of awareness of privacy guidelines and complaints procedures, or a reluctance to bring further attention to a transitory personal circumstance. Whatever the case may be, more than one provincial commissioner has thanked the journal for bringing this issue to their attention, and the Ontario College of Pharmacists has already agreed to revise their guidelines.<sup>3</sup> The question of the security of data in a convenience store or supermarket is moot, as off-the-shelf availability implies that no personal information would be requested in the first place.

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## Biopeptides and immune exclusion

Successful probiotics have the ability to adhere to the gut preventing attachment of pathogenic bacteria and help to restore immunologic quiescence. Unfortunately, Nandini Dendukuri and colleagues' systematic review<sup>1</sup> was unable to find clinical benefit for treatment of *Clostridium difficile*-associated diarrhea (CDAD).

The important question is, Can probiotics or biologically active peptides induce a lasting immune response? Probiotics stimulate the synthesis and secretion of polymeric IgA, the antibody that protects mucosal surfaces against harmful bacterial invasion, the concept underlying immune exclusion. Appropriate colonization with probiotics can thus help to produce a balanced T helper (Th) cell response. An imbalance in Th cells partly contributes to clinical disease: Th2 imbalance contributes to atopic disease and Th1 imbalance contributes to Crohn's disease and *Helicobacter pylori*-induced gastritis.

LeBlanc and colleagues<sup>2</sup> demonstrated that oral administration of an immunologically active peptide (derived after extensive proteolysis by *Lactobacillus helveticus*) enhanced immunomodulatory action and increased IgA+ B-lymphocytes in the intestinal lamina propria of mice, and offered protection against further *Escherichia coli* O157:H7 challenge. Benyacoub and colleagues<sup>3</sup> showed that the probiotic organism *Enterococcus faecium* SF68 offered specific humoral and cellular (increased CD4+ in Peyer's patches and spleen) responses against *Giardia intestinalis* infection in mice.

Perhaps we are just beginning to understand the complex coexistence and interdependence between microbes and man.

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